Physical Illness and Depression

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In business, the fastest way for a company to increase profits is not through new research but by making sure it gets paid for work it is already doing. In medicine, while research is needed for the field to keep advancing, the fastest way to improve the health and well-being of our patients is to recognize and treat correctable problems that have been overlooked.

The paper by Cadoret and Widmer in this month's journal is an important reminder about one of the most common, yet easily overlooked, sources of excess disability among the medically ill. Study after study has documented the frequent occurrence of depression among medically ill inpatients (most estimates are in the 25 percent to 30 percent range), and this study suggests a figure almost as high for outpatients. Study after study also shows that depression is not necessarily recognized when present and not necessarily treated when recognized.

Depression is not an unusually difficult diagnosis to make if the physician is attuned to it and there is adequate time during the appointment, but both of these elements (particularly the latter) can be difficult given the structure of a primary care practice. For a family physician to spend an uninterrupted 30 minutes with a patient is a rare luxury, yet this is only one half the time a psychiatrist usually takes to evaluate a new patient. Since the demands of primary care are unlikely to change, the challenge to the physician is to bring the needed knowledge, skills, and attitudes into the examining room and to apply them within the brief time available (a challenge not sufficiently appreciated by many behavioral scientists).

Some comments on each of these three factors (knowledge, skills, and attitudes) are in order. The necessary knowledge base includes knowing the DSM-III[1] diagnostic criteria for depression as well as currently accepted treatment practices. Clear, concise reviews on drug therapy for depression appear regularly in the medical literature, but physicians should also be aware that the recent National Institute of Mental Health collaborative study on depression does not show superiority for drug therapy over psychotherapy in milder cases (this news should be particularly welcome to physicians who strive to keep drug therapy to a minimum). Aside from the obvious consideration that severe depression usually requires somatic treatment, it is still unclear what form of therapy is best for specific cases of mild to moderate depression, but if the physician is knowledgeable about the treatment (whether behavioral therapy, family therapy, or an antidepressant combined with supportive psychotherapy) and the patient has confidence in the physician, there is a good chance for a successful outcome.

While the knowledge base can be obtained fairly quickly through continuing medical education courses or review articles, the skills may be harder won. Knowledge of the diagnostic criteria may not translate into including the necessary questions into the patient interview, and knowledge about treatment may not be enough to get the patient to comply. The keys to making the diagnosis are constantly to be alert to depression as a possibility, and at the appearance of even a single clue, such as a dysphoric mood, depressed appearance, or unexplained physical symptom, briefly to ask the questions that cover the DSM-III criteria (eg, How is your energy, appetite, sleep, interest level, and so on). A subtle reference to a symptom of depression is easily overlooked ("These headaches really take it out of me."), but with practice the diagnosis can often be ruled in or out in just a few minutes.

Compliance can be difficult to achieve, but patience and persistence increase the chances. The patient who insists the problem is physical can be advised that indeed it is, but he has also developed the added burden of depression, which intensifies pain as though putting it under a magnifying glass.

It may be that attitudes are the greatest barrier of all to recognition and treatment of depression, particularly in the elderly. This is the double-whammy of being both old and mentally ill, which has the unfortunate effect of causing physicians (including psychiatrists) to lower needlessly their expectations or even to lose interest completely. Regrettably, there is empirical evidence of attitudinal barriers on the part of psychiatrists (while I have no proof, I suspect attitudinal barriers also occur to some extent among family

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physicians), and evidence of such is also seen in Medicare regulations.

A study which involved sending questionnaires to physicians showed that case histories that were identical except for age-produced responses indicated that older patients were viewed as having a poorer prognosis and as less suitable for the responders' practices.[2] Medicare regulations reinforce this view, as the only major category of illness subject to a 50 percent deductible and low annual maximum for outpatient treatment by a physician is mental illness.

How can we improve in this area? The answers are to continue our efforts in education and research, and there is reason for optimism on both fronts.

Education can correct negative attitudes about the elderly. A review of studies related to correcting negative attitudes has shown benefits both at the medical student and house staff level, and family medicine educators should consider including appropriate content in their curricula.[3]

There is ample research showing the high prevalence of depression among medically ill elderly, so future research efforts are best directed toward adding new elements. For example, it would be helpful to know the prevalence of depression for specific medical diagnoses, along with the efficacy of various treatment strategies, both pharmacologic and nonpharmacologic. The efficiency and effectiveness of screening instruments (many of which are cumbersome to use in a busy office practice) can be compared with use of DSM-III criteria by the physician. And effectiveness of treatment for depression in reducing health care needs for other problems can be studied.

Paradoxically, the high rate of depression among medically ill elderly may itself be a factor in its underdetection, as physicians may come to regard depression as a normal occurrence. In fact, it is not unusual to hear the argument that anyone with a particular diagnosis would be depressed. Empirical evidence does not support this assumption, and clinical experience teaches us that many individuals with severe illnesses are not depressed. When depression is superimposed on a physical illness, we need the knowledge and skills to diagnose and treat and the clear awareness that relief of depression is a realistic and important goal even in advanced age and poor health.

References

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